Developing consensus description of group music therapy characteristics for persons with dementia

Janus, Sarah I. M. ; Vink, Annemieke C. ; Ridder, Hanne Mette Ochsner; Geretsegger, Monika; Stige, Brynjulf; Gold, Christian; Zuidema, Sytse U.

Published in:
Nordic Journal of Music Therapy

DOI (link to publication from Publisher):
10.1080/08098131.2020.1779790

Publication date:
2020

Document Version
Publisher's PDF, also known as Version of record

Citation for published version (APA):
Janus, S. I. M., Vink, A. C., Ridder, H. M. O., Geretsegger, M., Stige, B., Gold, C., & Zuidema, S. U. (2020). Developing consensus description of group music therapy characteristics for persons with dementia. *Nordic Journal of Music Therapy*, 1-17. https://doi.org/10.1080/08098131.2020.1779790

Nordic Journal of Music Therapy

30 (1) 2021

Nordic Journal of Music Therapy

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rnjm20

Developing consensus description of group music therapy characteristics for persons with dementia

Sarah I. M. Janus, Annemieke C. Vink, Hanne Mette Ridder, Monika Geretsegger, Brynjulf Stige, Christian Gold & Sytse U. Zuidema

To cite this article: Sarah I. M. Janus, Annemieke C. Vink, Hanne Mette Ridder, Monika Geretsegger, Brynjulf Stige, Christian Gold & Sytse U. Zuidema (2021) Developing consensus description of group music therapy characteristics for persons with dementia, Nordic Journal of Music Therapy, 30:1, 24-40, DOI: 10.1080/08098131.2020.1779790

To link to this article: https://doi.org/10.1080/08098131.2020.1779790

Published online: 26 Jun 2020.

NORDIC JOURNAL OF MUSIC THERAPY
2021, VOL. 30, NO. 1, 24–40
https://doi.org/10.1080/08098131.2020.1779790

Routledge
Taylor & Francis Group

ORIGINAL RESEARCH ARTICLE

OPEN ACCESS Check for updates

Developing consensus description of group music therapy characteristics for persons with dementia

Sarah I. M. Janus[a], Annemieke C. Vink[b], Hanne Mette Ridder[c], Monika Geretsegger[d], Brynjulf Stige[e], Christian Gold[d] and Sytse U. Zuidema[f]

[a]Department of General Practice and Elderly Care Medicine, University Medical Centre Groningen, University of Groningen, Groningen, The Netherlands; [b]Academy of Music, Music Therapy Department, ArtEZ University of the Arts, Enschede, The Netherlands; [c]Doctoral Programme in Music Therapy, Department of Communication and Psychology, Aalborg University, Aalborg, Denmark; [d]GAMUT - The Grieg Academy Music Therapy Research Centre, NORCE, Bergen, Norway; [e]Grieg Academy – Department of Music, Faculty of Fine Art, Music and Design, University of Bergen, Bergen, Norway; [f]Department of General Practice and Elderly Care Medicine, University Medical Centre Groningen, University of Groningen, Groningen, The Netherlands

ABSTRACT

Introduction: Group music therapy (GMT) represents a promising person-centered approach facilitating emotional and social interaction and alleviating behavioral and psychological symptoms in people with dementia. The aim of this study is to produce a consensus statement that can inform provision of and research on person-centered group music therapy (GMT) for persons with dementia.

Method: We used a Delphi consensus procedure of two iterations in which music therapists rated their agreement with predefined statements about descriptions of GMT in structured questionnaires. Music therapists from eight countries (Austria, Australia, Denmark, Germany, Italy, Netherlands, Norway and UK) participated in the Delphi iterations.

Results: In the first iteration 57 music therapists participated and 34 in the second iteration. Consensus was reached on 75 out of 91 statements covering five themes: (1) People who can benefit from GMT, (2) Short and long-term goals, (3) Therapy frame & Assessment (4) Therapeutic approaches within GMT and (5) Therapists' qualities and attitudes.

Discussion: This consensus statement provides therapists and researchers with practical information to which music therapists agree on an international level. It may serve as a foundation for developing more extensive and in-depth guidelines and fidelity measures. The statements underlinethat the music therapist must adapt therapy to the needs and wishes of persons with dementia, which can be seen in the consensus statements about group size, group dynamics, distractions and interruptions during the therapy.

ARTICLE HISTORY Received 1 August 2019; Accepted 14 May 2020

KEYWORDS Psychosocial therapy; person-centered; music therapists

CONTACT Sarah I. M. Janus s.i.m.janus@umcg.nl University Medical Centre Groningen, Department of General Practice and Elderly Care Medicine, 9700 AD Groningen, The Netherlands

Introduction

Behavioral and psychological symptoms associated with dementia are highly prevalent in elderly people and are associated with individual suffering and high societal costs. These symptoms are usually treated with pharmacological interventions such as psychotropic drugs (Janus et al., 2016). However, pharmacological interventions have only limited effect and are associated with adverse effects including increased mortality (Seitz et al., 2012). Guidelines therefore recommend non-pharmacological interventions as first treatment option (National Institute for Health and Care Excellence [NICE], 2016; Zuidema et al., 2018) which are also preferred by patients and their family members (Cohen-Mansfield & Mintzer, 2005). Furthermore, these symptoms in people with dementia can have many causes and are not necessarily direct consequences or expressed through behavior of the dementia itself (Gerritsen et al., 2019). Interventions that take the context and possible meaning of those behaviors into account are therefore needed.

Non-pharmacological interventions that are person-centered may be especially effective to long-term improvement in reducing behavioral and psychological symptoms (Sjögren et al., 2013). Kitwood (1997) defines person-centeredness as "a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust." (p. 8). Non-pharmacological interventions that incorporate the person-centered care approach therefore do not focus on the symptoms but on the unmet needs (Cohen-Mansfield & Mintzer, 2005). Therefore, "the interpersonal interactions of care staff must be such that persons with dementia are understood, especially in relation to their feelings" (Stein-Parbury et al., 2012, p. 408).

Music interventions – a broad category ranging from adjunctive music listening, through recreational singing, to music therapy as conducted by specifically trained music therapists – represent one promising group of non-pharmacological interventions to alleviate behavioral and psychological symptoms in people with dementia and to improve their overall quality of life using a person-centered approach. Specifically, music therapy using a person-centered approach focuses on the psychosocial needs of the person with dementia, thereby hoping to indirectly decrease behavioral and psychological symptoms, which may occur as a consequence of unmet needs; the resulting behavior change could even be described as a positive "side effect" (Ridder et al., 2013). Recent neuroimaging research has lent support to the clinically derived notion that music can address needs of people with dementia. Due to the relative preservation of medial frontal and limbic areas in the brain affected by dementia, music-induced emotions and memories are often preserved even in the more advanced stages of the disease (Jacobsen et al., 2015). Especially in the later phases of dementia, when verbal communication is often no longer possible, music offers a way to enable contact with the person with dementia. This enables the use of music-based therapeutic interventions across the dementia spectrum, from mild cognitive impairment to severe dementia (Van der Steen et al., 2018).

The most recent update of a series of Cochrane systematic reviews (Van der Steen et al., 2018) on the effects of music-based therapeutic interventions for people with dementia identified 22 studies with a total of 1097 participants with dementia. The review found "low-quality evidence that [music] interventions improve emotional well-being and quality of life (standardized mean difference (SMD) 0.32, 95% CI 0.02 to 0.62) and reduce anxiety (SMD −0.43, 95% CI −0.72 to −0.14)." Moderate-quality evidence was found for

the reduction of depressive symptoms and overall behavior problems. The review, which included only music-based therapeutic interventions of at least five sessions, concluded that these interventions lead to less depressive symptoms and other behavioral problems (Van der Steen et al., 2018). However, the authors evaluated the included trials to be of low quality and suspect that the effects are affected by the type of music interventions that are often described in brief descriptions and lacking precise detail about the specific intervention being offered. Vink and Hanser (2018) also suggest that more detailed intervention descriptions would improve clinicians' knowledge and lead to better replications of study protocols. Besides, current treatment guidelines recommending music interventions vary in their degree of specificity. The NICE Guideline Dementia (2016) recommends "therapeutic use of music" quite generally. Other European guidelines concerning the treatment of dementia and challenging behaviors refer to the use of music as a treatment (Danish Health Authority, 2019; Zuidema et al., 2018).

Among the many music interventions in dementia that exist, this study focuses on group music therapy (GMT), which is relatively well-studied. In the MIDDEL trial (Gold et al., 2019) which provides the context for this study, GMT is provided by specialized music therapists in small groups and uses various activities ranging "from singing through instrumental music making to music listening" (Gold et al., 2019, p. 2). However, no common best practice guideline or consensus description exists for providing GMT. In scientific studies, there is a need to describe the precise intervention being offered, including overall timeframe, duration of each session, group size, specific therapeutic goals, and content of the sessions.

Standardization is not a goal in itself. It can be argued that there is also a need to retain the flexibility (or even the artistic freedom) of both therapists and clients (Collins & Fleming, 2017). However, more precise descriptions of music therapy interventions would make comparisons between different countries less complicated for scientific research, and lead to a more consistent quality of the offered music therapy in the different countries and to more recognition of music therapy as an effective intervention. Therefore, the aim of this study is to produce a consensus statement for GMT that includes a set of detailed principles and therapy intentions that provide guidance for person-centered GMT for persons with dementia. The article is a record of work by scientific and clinical experts from different countries using a modified Delphi consensus procedure in order to be independent of experts' own individual preferences.

Method

We used a Delphi consensus procedure (Biondo et al., 2008) of two iterations in which music therapists rated their agreement with predefined statements about descriptions of GMT in structured questionnaires. The research team drafted the statement list together with international experts, provided the statement list to the panelists and proposed changes of the questions/statements at each consecutive Delphi iteration. Music therapists participated in the Delphi iterations and responded to the statements. Therefore, this Delphi procedure consisted of two phases.

Phase 1: Drafting of statements by a core group

In the first qualitative and unstructured round, a core group of seven experts from four countries (the authors) drafted a set of statements based on literature, professional

expertise and personal experiences. The core group consisted of a subgroup of authors who developed the study protocol for the "Music Interventions for Dementia and Depression in Elderly Care (MIDDEL) trial" (Gold et al., 2019) combining expertise in music therapy, medicine, epidemiology and research methodology. The group consisted of members from Austria, Denmark, Germany, Netherlands and Norway. All members were knowledgeable about music therapy or dementia care (mostly both) based on research, education or clinical experience. The draft set was developed during November 2017 and January 2018. During a face-to-face meeting, the experts discussed and developed the topic list. A member of the core group then drafted the first list of statements. Members of the core group reviewed the list, and subsequently met as a group (skype meeting) to discuss discrepancies and finalize the consensus document.

Phase 2 and 3: Evaluation by an expert panel with online survey (Delphi round 1 and 2)

In spring 2018, the core group invited music therapists from eight countries (Austria, Australia, Denmark, Germany, Italy, Netherlands, Norway and UK) to evaluate the domains and recommendations in a two-round online survey. Music therapists were seen as experts when they had experience in working with persons with dementia and were first purposefully invited to participate, having been identified through the networks of the core group. In a later stage, newsletters and social networks were used to recruit music therapists with experience in working with persons with dementia.

In Delphi round 1 the list of statements developed in phase 1 were used. The list comprised 91 statements covering 8 themes that could be agreed upon or not on a 9-point Likert scale (1 = no consensus, 9 = full consensus). Statements for which full consensus was reached were included in the consensus survey. Statements with no consensus were discussed with parts of the core group and rephrased if necessary and reiterated in the final round. Consensus was determined according to predefined criteria. In the second round, we included only items on which full consensus was not reached in round one. Therefore, the questionnaire was shorter than the first one. In both rounds, participants were able to comment on the different statements.

Analysis

Scores were analyzed after each of the two rounds and comments were used to improve the indicators. For a statement to be accepted in the statement list, two requirements had to be met. The first requirement was that participants agreed with the statement, which meant that the panel's median score was in the upper tertile of the rating scale, between 7 and 9. The second requirement was that participants agreed among each other. Such agreement between the participants was assessed with the inter-percentile range (IPR) adjusted for symmetry (IPRAS) (Fitch et al., 2001). In the present case the 70% to 30% IPR was used, as done in previous studies (Zuidema et al., 2015). According to the RAND/UCLA method (Fitch et al., 2001), if for a given indicator the IPRAS is larger than the IPR, there is agreement among the participants and if the IPRAS is smaller than the IPR, there is disagreement.

For any given indicator, if the panel's median score was in the lowest tertile of the scale or between 1 and 3, and if there was agreement among participants, then the

statement was rejected. In all other cases, the indicator was judged uncertain, was rephrased and was resubmitted for a second round of validation. Final acceptance of an indicator after the second round was limited to those that reached agreement by the panelists.

Ethical considerations

The necessary ethical approval was obtained from the Ethics Committee of the University Medical Centre of Groningen (number M17.216699). The authors adhered to research ethics thus, before the start of the online questionnaire, respondents were shown the informed consent form (information on the purpose of the study, background, (stopping) participation, usage and storage of the data and contact information of the researcher). Only participants giving consent (clicking on "I agree" button) were directed to the online questionnaire.

Results

Participants involved

A total of 57 respondents participated in the first iteration (see Table 1). In the second iteration, 34 music therapists participated (94% participated also in round 1).

In total, 42 respondents answered to questions concerning the GMT characteristics for persons with dementia (see Table 2). The music therapists from the UK, Germany and Australia reported to work on average with 12–13 persons with dementia per

Table 1. Demographics of respondents

Total number of respondents	N = 59
Number respondents per iteration, n	
Iteration 1	57
Iteration 2	34 (2 new, 32 former participants)
Geographical coverage, n (%)	
Austria	3 (5.1)
Australia	7 (11.9)
Denmark	6 (10.2)
Germany	13 (22.0)
Italy	6 (10.2)
Netherlands	15 (25.4)
Norway	6 (10.2)
United Kingdom	3 (5.1)
Age in years, Mean (SD)	44 (10.5)
Gender female, n (%)	46 (78.0)
Experience in music therapy practice in years, Mean (SD; range)	12.1 (7.8; 2–37)
Experience in music therapy practice with elderly in years, Mean (SD; range)	11.4 (7.7; 1–37)
Currently working as music therapist, n (%)	53 (89.8)
Setting for music therapy*	
Nursing home/rehabilitation center/hospice	58 (98.3)
Hospital	5 (8.5)
Day care center	6 (10.2)
Private music therapy	11 (18.6)
Other	5 (8.5)
Treating persons with dementia using GMT, n (%)	41 (69.5)

SD = standard deviation, * More than one response possible.

Table 2. GMT characteristics per country

	Group size of GMT, Mean (SD; range)	Number of sessions per week a person with dementia receives GMT, Mean (SD; range)	Average duration of GMT session in min, Mean (SD; range)
Austria, N = 3	7 (4.0; 3–11)	1.0 (0.0; 1–1)	48.3 (12.6; 35–60)
Australia, N = 7	13 (5.1; 7–20)	0.9 (0.2; 0.5–1)*	54.2 (11.3; 30–60)
Denmark, N = 2	9 (1.4; 8–10)	2.5 (0.7; 2–3)	52.5 (10.6; 45–60)
Germany, N = 12	13 (6.8; 5–25)	1.5 (0.9; 1–4)	56.7 (6.2; 45–60)
Italy, N = 4	6 (3.1; 3–10)	1.8 (1.6; 0.5–4)	42.5 (32.1; 20–90)
Netherlands, N = 9	7 (2.1; 5–10)	1.9 (3.1; 0.5–10)	50.6 (7.7; 40–60)
Norway, N = 3	9 (2.3; 6–10)	1.3 (0.6; 1–2)	45.0 (0.0; 45–45)
UK, N = 2	12 (5.7; 8–16)	1.5 (0.7; 1–2)	67.5 (31.8; 45–90)
All countries, N = 42	10 (5.2; 3–25)	1.5 (1.5; 0.5–10)	52.5 (13.5; 20–90)

SD = standard deviation, *1 answer was identified as outlier (20 sessions per week) and excluded.

group. Music therapists working in Italy reported to work with smaller groups consisting of six persons. On average GMT is offered once or twice per week to the person with dementia for on average 45–60 min.

Agreement on statements

Respondents reached agreement with median values between 7 and 9 on 65 of 91 statements in the first and 10 out of 14 statements in the second questionnaire. In total, the respondents reached agreement on 75 statements with median score between 7 and 9 that were included into the statement list (Table 3).

Content of the statements

The full version of the consensus consists of the statements presented in Tables 4–7. The statement list addresses five main themes that are described below (see Tables 4–7). The excluded statements are mainly those that were added by the authors to come to more specific definitions of GMT about aspects such as group characteristics, group size or therapists' qualities (full list of deleted statements see Appendix).

People with dementia who can benefit from GMT

The survey asked about the character of GMT for people with dementia. The music therapists agreed that GMT might be helpful for persons during all stages of the

Table 3. Results iteration 1 and 2

Iteration	Iteration 1	Iteration 2
Number of statements	N = 91	N = 14
Median 7–9/consensus*	65	10
Median 4–6/consensus	9	2
Median 1–3/consensus	3	1
Median 7–9/disagreement	3	0
Median 4–6/disagreement	11	1
Median 1–3/disagreement	0	0

*Only statements with median 7–9/consensus were copied into the consensus document.

Table 4. Statements relating to people who can benefit from GMT

	People with dementia who can benefit from GMT
1	GMT may be offered to persons with dementia at various stages of the disease and for many therapeutic purposes.
2	GMT should not be offered to all persons with dementia with behavioral and psychological symptoms*, but should depend on the personal circumstances, wishes and perceived benefit of the person with dementia.
3	GMT may be offered to persons with dementia at the first stage of the disease, which is characterized by a decrease in memory functions, disorientation, and changes in personality.
4	GMT may be offered to persons with dementia at the middle stage of the disease, which is characterized by decreased memory functions, an increase in major psychological disorders such as hallucinations and psychoses, and an increase in behavioral disorders such as verbal and physical aggression.
5	GMT may be offered to persons with dementia at the latest stage of the disease, which is characterized by a decrease in overall functioning: inability to speak, family members are no longer recognized, loss of psychomotor skills, person becoming bedridden.
6	GMT is an important contribution, alongside medication, rehabilitation and individual therapy and should therefore be offered as part of integrated treatment.
7	GMT can be helpfully combined with psychotropic medication.
8	GMT can be helpfully combined with individual psychosocial interventions.

dementia process. GMT can be offered alongside other therapies such as treatment with psychotropic drugs and other psychosocial interventions.

Short and long-term goals

Participants agreed that what was specific and particular about GMT for persons with dementia was an attempt to understand and help clients to reduce any emotional distress or dissatisfaction and encourage social interaction between group members as short-term goals of GMT. There was also agreement that the overall aim of group music therapy is to facilitate social engagement and self-expression to fulfill psychosocial needs by enhancing the client's identity, which is assumed/expected according to the participants to lead to less behavioral and psychological symptoms and psychotropic drug use.

Therapy frame & Assessment

The participants agreed that a requirement for GMT is offering a constant setting with regards to therapy arrangements for the persons with dementia. In addition, music therapists should stay in close contact with other health care professionals to determine the treatment goals. The therapist should respond to the individual needs of the client, in case of behavioral and psychological problems during the therapy session. This requires adjustment of the therapy and therapist's behavior in moments needed. Different contents might be used during GMT, such as active techniques, for example, improvisation, and receptive techniques, for example, listening to live or recorded music. All participants agreed that music therapists must use individual musical attunement during therapy. Musical attunement describes the process whereby the therapist sensitively and musically responds to a client's musical and non-musical expression in order to "tune in" empathically (e.g. Stern, 1985).

Participants argued that the type and level of intervention should depend on the needs of the individual. Interventions should depend on "the situation, the person's needs, client preferences and the group dynamics" according to comments of the panelists.

Table 5. Statements relating to therapy goals, frame & assessment

Short-term goals within therapy	
9	GMT should aim to create a safe setting for persons with dementia.
10	When the person with dementia feels safe, GMT should aim to regulate the arousal level of the person with dementia to a point where he/she is open to social interaction.
11	GMT helps persons with dementia to form and maintain rewarding relationships with other people.
12	GMT should aim to promote the maintenance of the sense of identity in people with dementia.
13	GMT should aim to stimulate the global cognitive functions.
14	GMT should aim to support the client's physiological, mental and social resources by using music experiences.
15	GMT should aim to increase socialization between the therapists and peers to decrease isolation and improve mood for persons with dementia.
16	GMT should aim to improve the attention in the here and now in persons with dementia.
17	GMT should aim to remove any distress in persons with dementia.
18	GMT should aim to improve the person's emotional functioning.
19	During the GMT session, the therapist should try to create an atmosphere of trust to decrease participants' isolation.
Long-term goals for therapy after repeated sessions	
20	GMT should aim to improve quality of life.
21	GMT should aim to improve cognitive functioning in persons with dementia.
22	GMT should aim to decrease agitation (i.e. less wandering behavior, less restlessness) in persons with dementia.
23	GMT should aim to decrease physical and verbal aggressive behavior in persons with dementia.
24	GMT should aim to decrease anxiousness in persons with dementia.
25	GMT should aim to decrease apathy in persons with dementia.
26	GMT should aim to decrease depressive symptoms in persons with dementia.
27	Persons with dementia should be more attentive as a result of GMT.
28	The goals (such as social engagement or stress reduction) of each GMT session should serve the long-term goals (improvements of behavior and mood).
29	GMT should lead to less psychotropic drug prescriptions for the person with dementia and behavioral and psychological symptoms
Therapy Frame and Content	
30	Therapists must ensure that the setting is kept constant, they should be clear with the persons about the circumstances in which the therapy arrangements might change.
31	Therapists should ensure that the setting is kept constant, for example, the same therapist should lead the GMT for one particular group.
32	If a person shows behavioral and psychological problems during therapy, this should not be an indication for early termination of therapy.
33	If a person shows behavioral and psychological problems during therapy, the therapist should respond to the needs of that particular person.
34	If a person shows behavioral and psychological symptoms, which cannot be reversed by the therapist or staff members and they negatively influence the atmosphere of the group, the person may temporarily be excluded from GMT sessions.
35	The group size should not be too big in order to focus on delivering person-centeredness to individual patients.
36	An essential part of therapy is that the therapist can adjust to each individual need if the moment requires this.
37	Therapists should liaise with other health professionals involved in the persons' care to unify the treatment goals for the person with dementia.
38	Receptive music therapy is appropriate in GMT for persons with dementia. Receptive music therapy means sessions where persons listen to music that the therapist plays or sings.
39	Active music therapy (such as improvisation and active participation) is appropriate in GMT for persons with dementia.
40	During GMT for persons with dementia, the therapist must use musical attunement, which requires various musical and empathic techniques to encourage the person to listen and be aware of self and others.
41	During GMT for persons with dementia, music based on musical preferences of the person should be used.
42	During GMT for persons with dementia, the therapist may support the participants to engage in improvisation.

(*Continued*)

Table 5. (Continued).

Assessment and preparatory sessions	
43	During the preparatory observation session(s) the therapists should listen to and attune to their clients.
44	Therapists should decide if the already existent group would match the new person's needs and level of functioning.
45	A music therapeutic assessment should take place in order to select a suitable location without distractions for the GMT to take place.

Table 6. Statements relating to therapy approach & therapy elements

General Therapy Approach throughout Assessment and Therapy	
46	GMT should focus on developing and maintaining the therapeutic alliance throughout therapy.
47	Therapists should help persons manage their feelings by helping them to stay with painful emotions rather than rush away from them.
48	Therapists should create a supportive atmosphere with the intent of helping the participant feel welcome and valued.
49	Therapists should help persons explore their own thoughts by building links between persons' experiences and thoughts.
50	If therapists feel that a person in the group is at risk of harmful interactions with other persons, they should act to keep the person safe by distracting the person at risk.
51	In the first period of the therapy process, an evaluation by the therapist should take place to ensure that GMT is appropriate for the person with dementia.
52	Regular assessments should document the individual's persistent need of GMT.
53	An end-of therapy assessment with a report on outcomes should take place to conclude the case.
54	If the predefined therapy goal/s is/are met, the therapist evaluates whether therapy should continue with new goals to avoid deterioration of symptoms, or whether therapy should be concluded.
Elements of a GMT session to make GMT person-centered	
55	Using non-verbal but vocal or instrumental exchanges, the therapist tries to establish a relationship with the client by identifying musical elements (temporal beat, rhythmic patterns, dynamics of expression, pitch range and melodic contour) in the client's behavior.
56	The therapist's vocal or instrumental exchanges should provide a predictable, empathic and supportive musical structure to attract and engage the client.
57	During the GMT sessions, the therapist should try to engage participants who do not actively participate by talking to them or making eye contact.
58	During the GMT sessions, the therapist should facilitate the participants' movement to music with verbal, visual, or tactile cues.
59	During the GMT sessions the therapist should facilitate the participants' movement (physical movements such as dancing, hand clapping) to music by reflecting and amplifying the movement that arises spontaneously from the participants.
60	During the GMT sessions, the therapists can use reminiscence (a method whereby elderly people usually in a group retrieve memories of their youth).
61	During the GMT sessions, participants can be invited to reflect upon their individual biography, for example, when choosing songs to sing.
62	GMT sessions should have certain recurrent rituals such as a typical starting song for people to recognize the start of the session.
63	Depending on the context and setting, the therapist may invite other clients, care staff and relatives to participate in the GMT sessions.
64	During the GMT sessions, the therapist validates the participants' emotions.
65	Depending on the context and participants' needs, the therapist may offer verbal reflections after musical actions, e.g. to help participants in becoming conscious of a cognitive resource, to express feelings and memories or to encourage communication about shared experiences.
66	During the GMT sessions, therapists can choose songs or music to listen to according to the emotional states of individual group members or of the whole group.
67	GMT sessions should have a recurrent closing song at the end of each session to get the participants ready to leave the music therapy space.
68	After each GMT session, the therapist should evaluate the session according to its therapy goals.
69	After each GMT session, the therapist should write down his/her impressions of the person's participation.

Table 7. Statements relating to the therapist

Therapists' Qualities and Attitudes	
70	Therapists must be active listeners.
71	Therapists must maintain an analytic attitude.
72	Therapists must be patient, empathic and non-judgmental in their style.
73	Therapists must be able to respect a slow pace of change and be able to recognize and acknowledge small steps in the persons' development.
74	Therapists must be trained as a music therapist.
75	Therapists must be trained as a musician.

Therapeutic approaches within GMT

Participants agreed that GMT should enable clients to get in contact with difficult feelings and try to link experiences and thoughts. The therapist should be flexible regarding individual clients and their capacities. In addition, participants agreed that evaluations should take place to determine the appropriateness of GMT for the person, to evaluate the person's need for GMT and to document the results of GMT for the person. Furthermore, participants agreed that therapists should evaluate if goals are met, whether therapy should continue with new goals to avoid deterioration of symptoms, or whether therapy should be concluded.

The participants agreed that a wide variety of music therapy methods and techniques can be used in GMT. Vocal or instrumental improvising, singing (to well-known songs, unknown songs or pre-recorded music), dancing/moving (to live or pre-recorded music), listening (to live or pre-recorded music), and other activities (talking, etc.) are encouraged by the participants. One of the panelists explains the broad therapy approach and the variety of elements used in GMT with the need for being able to adjust to the changing environment: "*In my experience, the structure of group music therapy sessions needs to be flexible and adaptable according to the dynamics on a given day, along with other variables such as staff and family members attending and contributing to sessions.*"

The panel agreed that the sessions should have a certain structure using rituals, such as a starting or closing song, that signalize closure and stability. According to the participants, the music therapists should evaluate GMT sessions. However, no consensus was reached on the use of a validated/standardized questionnaire for the evaluations of the person with dementia. Even though some music therapists could see the value of such a form: *"I think that some kind of standardized evaluation forms from our Music Therapy associations would help our places of work to recognize the therapeutic value of what we do as therapists, and to not just see us as entertainers."*

Therapists' qualities and attitudes

In the Delphi survey, the music therapists agreed that therapists must have an analytic attitude and be empathetic and non-judgmental in their style. They also agreed that music therapists should have adequate training in music therapy and as musicians. The statement "Therapists must be trained as a musician without necessarily being trained as a music therapist." did not reach consensus.

Discussion

With the robust process of a modified Delphi technique along with a core group of scientific and music therapy experts as well as a large number of panelists with practical experiences in (group) music therapy, we ended up with a set of 75 out of 91 statements that were incorporated into a consensus statement. This statement provides therapists and researchers with written key practical information of group music therapy for persons with dementia to which music therapists agree on an international level.

Importance of a consensus statement

Based on the literature (Ueda et al., 2013) and comments left in our questionnaire, we recognize a great need to achieve consensus on the basic principles of GMT and person-centeredness. More precise descriptions of GMT could lead to better awareness, recognition and acceptance of this approach by physicians, other health care professionals and nursing home managers. A rigorously designed structured form of GMT is likely to improve the replicability of a music therapy intervention, both in clinical practice and in research studies, which will improve the body of knowledge on effective music-based therapeutic intervention. However, music therapy cannot be offered as a cookbook recipe. In clinical practice, the music therapist must adapt therapy goals continuously to the diverse group of persons with dementia, the possibility to provide person-centered GMT in large groups and individual approaches of the therapists. Such an approach focuses on the needs of the persons with dementia. This is also reflected in the statements representing the elements of a GMT session to make GMT person-centered (see Table 6). These statements underline among other things the focus on the emotional states and recognition of the feelings of the persons with dementia. These elements are also partly described in a recent intervention fidelity protocol by Baker et al. (2019). In the protocol, she describes possible therapeutic techniques that music therapists may use to make GMT person-centered (e.g. recognition, validation).

A balance between standardization and flexibility

On many statements consensus was reached even though the panelists in our study had different geographical backgrounds, belonged to various theoretical schools and had diverse training backgrounds, which possibly affected the way therapists apply GMT and respond to their clients. Discussions in the scientific literature reflect the challenge to find a good balance between standardization and flexibility. For research purposes, a previous study suggested the use of a therapeutic manual for resource-oriented music therapy describing the therapeutic principles rather than the specific techniques used in therapy (Rolvsjord et al., 2005).

In addition, therapy approaches need to be broad enough to accommodate different circumstances in the group dynamics on any given day. In the end, music therapists have to cope with the ever-changing circumstances regarding the availability of space for GMT, group size, group dynamics, distractions and interruptions during the therapy session are reflected in this consensus statement.

Whereas previous research involving GMT differed regarding the overall structure (Chu et al., 2014; Ledger & Baker, 2007), the proposed consensus statement provides

help in structuring each session. Since this consensus statement is based on the experiences of music therapists, it provides useful tools to bridge the gap between clinical practice and scientific rigor. This consensus description may lead to a more mutual agreed structure of GMT sessions used in research so that different studies can be compared more easily, or, in contrast, instead of a uniform approach it may lead to clearer descriptions of what distinguishes one clinical manual from another when it comes to GMT characteristics. This clarity will improve the quality of clinical practice and research studies, and will make studies more comparable. The implementation and critical evaluation of this consensus statement is expected to lead to more precisely articulated GMT approaches, which will result in increased quality of GMT as a treatment of behavioral and psychological symptoms in dementia.

In this consensus statement, we did not try to reach consensus on the frequency and length of the GMT sessions, since this is highly dependent on the financial possibilities given to the music therapist or person with dementia in each country. However, differences can be found in the literature (Raglio et al., 2010) and are also reported by the panelists in this study. GMT might have different effects depending on the frequencies, such as a daily or weekly basis. The influence of the different frequencies of sessions and various lengths of intervention on the efficacy of GMT needs to be further studied.

Consensus on GMT goals

The broad therapy approach of GMT can also be seen in the long-term goals that achieved consensus by the panelists. According to the music therapists, GMT aims to decrease behavioral and psychological symptoms, improve social engagement and attention span and improve overall quality of life of the person with dementia. However, the potential to improve these has been already demonstrated in previous studies (Ahonen-Eerikäinen et al., 2007; Raglio et al., 2010).

Strengths and limitations

The Delphi methodology allowed for efficient work with geographically dispersed music therapists. Therefore including panelists of six European countries and Australia became feasible. We focused on collecting data from these countries due to the availability of our contacts to music therapists there. Whether the guideline also applies to other countries, especially non-Western countries, is currently unknown, but would be interesting to investigate. We adopted a method for calculating consensus that accounted for the dispersion of ratings among the respondents as well as the internal symmetry between ratings. Furthermore, we collected the reactions by the panel independently and anonymously from the rest of the panel in order to eliminate subject bias.

While the Delphi technique attempts to avoid some of the disadvantages of traditional group decision making processes such as the risk of meetings dominated by one individual, it is criticized that the approach leads to generalities that represent the lowest common denominator of a debate. A limitation is the relative high variability of the numbers of music therapists across the different countries, with, for example, only three participants from the UK. Therefore, UK music therapists' views may be underrepresented. Due to the purposive nature of the sampling and the utilization of professional networks to contact participants no exact response size can be calculated. However, comparable international studies have reported similar biases, especially when research involves experts from different countries

(Annear et al., 2014). Due to our sampling strategy, we had little influence on the final selection of the panel and the precise nature of their expertise. It is possible that participants with specific interest and involvement with the issue were more likely to be involved in the Delphi and therefore biased the results. In hindsight, some of the statements formulated include multiple constructs (for example, statement 1 "GMT may be offered to persons with dementia at various stages of the disease and for many therapeutic purposes") making it difficult to discern the construct rated. Therefore, further work will be required to test the usefulness and applicability of the proposed guideline to the work of researchers and music therapists.

Conclusion

This consensus statement provides to our knowledge the first internationally validated description of current practices in group music therapy focusing on a person-centered approach facilitating emotional and social interaction and alleviating behavioral and psychological symptoms of dementia. This document provides a foundation for further critical reflection and may serve as a baseline for scientific studies. Therefore, it should not be seen as restricting music therapists' flexibility to adapt their interventions to the needs of patients and to specific circumstances of therapy as can be seen by the consensus statements about group size, group dynamics, distractions and interruptions. In addition, it might be used as input for the construction of a treatment guideline by a more diverse range and a larger number of music therapists using more group discussions reflecting the clinical practice. This could also include further exploration of special features of GMT as compared to individual therapy for people with dementia, such as diverse opportunities for social interaction, and different group format options. The usability of such guidelines should be tested in practice leading to treatment fidelity measures and framework for research projects involving international collaborations.

Disclosure statement

Monika Geretsegger is Managing Editor of the Nordic Journal of Music Therapy. To avoid conflict of interest, Monika Geretsegger was fully masked to the editorial process including peer review and editorial decisions and had no access to records of this manuscript.

Funding

No funding was received for this study.

Acknowledgments

We thank the music therapists who participated in our study for their valuable contributions.

Notes on contributors

Sarah I. M. Janus, PhD, has been trained as a psychologist and health scientist and works as a researcher at the department of Elderly Care Medicine and Dementia at University Medical Centre in Groningen, the Netherlands

Annemieke C. Vink, PhD, has been trained as a psychologist and works as a music therapy teacher at the Conservatory in Enschede, the Netherlands.

Hanne Mette Ridder, music therapist, PhD, is Professor at the 5-year MA training in music therapy and Head of the Doctoral Programme in Music Therapy at Department of Communication and Psychology, Aalborg University.

Monika Geretsegger, PhD, music therapist and clinical psychologist, is a Senior Researcher at GAMUT – The Grieg Academy Music Therapy Research Centre, NORCE Norwegian Research Centre, Bergen, Norway.

Brynjulf Stige, PhD, Professor at the University of Bergen (UiB), and Research Professor at GAMUT – The Grieg Academy Music Therapy Research Centre, UiB and NORCE Norwegian Research Centre; leader of POLYFON knowledge cluster for music therapy, Bergen, Norway.

Christian Gold, PhD, Research Professor at NORCE Norwegian Research Centre; Professor at the University of Bergen, Norway; Adjunct Professor, Aalborg University, Denmark; Professorial Research Fellow, University of Vienna, Austria.

Sytse U. Zuidema, MD, PhD, is a professor on Elderly Care Medicine and Dementia at the Department of General Practice at the University Medical Center Groningen.

ORCID

Hanne Mette Ridder http://orcid.org/0000-0002-3204-5997

References

Ahonen-Eerikäinen, H., Rippin, K., Sibille, N., Koch, R., & Dawn, D. (2007). "Not bad for an old 85-year-old!" – The qualitative analysis of the role of music, therapeutic benefits and group therapeutic factors of the St. Joseph's Alzheimer's adult day program music therapy group. *Canadian Journal of Music Therapy*, *13*(2), 37–62.

Annear, M., Lea, E., & Robinson, A. (2014). Are care workers appropriate mentors for nursing students in residential aged care? *BMC Nursing*, *13*(1), 1–16. https://doi.org/10.1186/s12912-014-0044-8

Baker, F., Tamplin, J., Clark, I. N., Lee, Y. C., Geretsegger, M., & Gold, C. (2019). Treatment fidelity in a music therapy multi-site cluster randomized controlled trial for people living with dementia: The MIDDEL project intervention fidelity protocol. *Journal of Music Therapy*, *56*(2), 125–148. https://doi.org/10.1093/jmt/thy023

Biondo, P. D., Nekolaichuk, C. L., Stiles, C., Fainsinger, R., & Hagen, N. A. (2008). Applying the Delphi process to palliative care tool development: Lessons learned. *Supportive Care in Cancer*, *16*(8), 935–942. https://doi.org/10.1007/s00520-007-0348-2

Chu, H., Yang, C. Y., Lin, Y., Ou, K. L., Lee, T. Y., O'Brien, A. P., & Chou, K. R. (2014). The impact of group music therapy on depression and cognition in elderly persons with dementia: A randomized controlled study. *Biological Research for Nursing*, *16*(2), 209–217. https://doi.org/10.1177/1099800413485410

Cohen-Mansfield, J., & Mintzer, J. E. (2005). Time for change: The role of nonpharmacological interventions in treating behavior problems in nursing home residents with dementia. *Alzheimer Disease & Associated Disorders*, *19*(1), 37–40. https://doi.org/10.1097/01.wad.0000155066.39184.61

Collins, F. S., & Fleming, R. (2017). Sound health: An NIH-Kennedy Center initiative to explore music and the mind. *Journal of the American Medical Association*, *317*(24), 2470–2471. https://doi.org/10.1001/jama.2017.7423

Danish Health Authority. (2019). *National Clinical Guideline for the prevention and treatment of behavioral and psychological symptoms in persons with dementia* [NKR: Forebyggelse og behandling af adfærdsmæssige og psykiske symptomer hos personer med demens]. https://www.sst.dk/da/Udgivelser/2019/NKR-Forebyggelse-og-behandling-af-adfaerdsmaessige-og-psykiske-symptomer-hos-personer-med-demens

Fitch, K., Bernstein, S. J., Aguilar, M. D., Burnand, B., LaCalle, J. R., Lazaro, P., Van Het Loo, M., McDonnell, J., Vader, J., & Kahan, J. P. (2001). *The RAND/UCLA appropriateness method user's manual* (No. RAND/MR-1269-DG-XII/RE). RAND CORP.

Gerritsen, D. L., Smalbrugge, M., Veldwijk-Rouwenhorst, A. E., Wetzels, R., Zuidema, S. U., & Koopmans, R. T. (2019). The difficulty with studying challenging behavior. *Journal of the American Medical Directors Association*, *20*(7), 879–881. https://doi.org/10.1016/j.jamda.2019.01.148

Gold, C., Eickholt, J., Assmus, J., Stige, B., Wake, J. D., Baker, F. A., Tamplin, J., Clark, I., Lee, Y. E. C., Jacobsen, S. L., Ridder, H. M. O., Kreutz, G., Muthesius, D., Wosch, T., Ceccato, E., Raglio, A., Ruggeri, M., Vink, A., Zuidema, S., Odell-Miller, H., & Geretsegger, M. (2019). Music Interventions for Dementia and Depression in ELderly care (MIDDEL): Protocol and statistical analysis plan for a multinational cluster-randomised trial. *BMJ Open*, *9*(3), e023436. https://doi.org/10.1136/bmjopen-2018-023436

Jacobsen, J. H., Stelzer, J., Fritz, T. H., Chételat, G., La Joie, R., & Turner, R. (2015). Why musical memory can be preserved in advanced Alzheimer's disease. *Brain,138*(8), 2438–2450.

Janus, S. I. M., Van Manen, J. G., IJzerman, M. J., & Zuidema, S. U. (2016). Psychotropic drug prescriptions in Western European nursing homes. *International Psychogeriatrics*, *28*(11), 1775–1790. https://doi.org/10.1017/S1041610216001150

Kitwood, T. (1997). *Dementia reconsidered: The person comes first*. Open University Press.

Ledger, A. J., & Baker, F. A. (2007). An investigation of long-term effects of group music therapy on agitation levels of people with Alzheimer's disease. *Aging and Mental Health*, *11*(3), 330–338. https://doi.org/10.1080/13607860600963406

National Institute for Health and Care Excellence [NICE]. (2016). *NICE clinical guideline 42: Dementia. Supporting people with dementia and their carers in health and social care*. guidance.nice.org.uk/cg42

Raglio, A., Bellelli, G., Traficante, D., Gianotti, M., Ubezio, M. C., Gentile, S., Villani, D., & Trabucchi, M. (2010). Efficacy of music therapy treatment based on cycles of sessions: A randomised controlled trial. *Aging and Mental Health*, *14*(8), 900–904. https://doi.org/10.1080/13607861003713158

Ridder, H., Stige, B., Qvale, L., & Gold, C. (2013). Individual music therapy for agitation in dementia: An exploratory randomized controlled trial. *Aging and Mental Health*, *17*(6), 667–678. https://doi.org/10.1080/13607863.2013.790926

Rolvsjord, R., Gold, C., & Stige, B. (2005). Research rigour and therapeutic flexibility: Rationale for a therapy manual developed for a randomised controlled trial. *Nordic Journal of Music Therapy*, *14*(1), 15–32. https://doi.org/10.1080/08098130509478122

Seitz, D. P., Brisbin, S., Herrmann, N., Rapoport, M. J., Wilson, K., Gill, S. S., Rines, J., Le Clair, K., & Conn, D. (2012). Efficacy and feasibility of nonpharmacological interventions for neuropsychiatric symptoms of dementia in long term care: A systematic review. *Journal of the American Medical Directors Association*, *13*(6), 503–506.e2. https://doi.org/10.1016/j.jamda.2011.12.059

Sjögren, K., Lindkvist, M., Sandman, P. O., Zingmark, K., & Edvardsson, D. (2013). Person-centredness and its association with resident well-being in dementia care units. *Journal of Advanced Nursing*, *69*(10), 2196–2206. https://doi.org/10.1111/jan.12085

Stein-Parbury, J., Chenoweth, L., Jeon, Y. H., Brodaty, H., Haas, M., & Norman, R. (2012). Implementing person-centered care in residential dementia care. *Clinical Gerontologist*, *35*(5), 404–424. https://doi.org/10.1080/07317115.2012.702654

Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis developmental psychology*. Basic Books.

Ueda, T., Suzukamo, Y., Sato, M., & Izumi, S. I. (2013). Effects of music therapy on behavioral and psychological symptoms of dementia: A systematic review and meta-analysis. *Ageing Research Reviews*, *12*(2), 628–641. https://doi.org/10.1016/j.arr.2013.02.003

Van der Steen, J. T., Van Soest-Poortvliet, M. C., Van der Wouden, J. C., Bruinsma, M. S., Scholten, R. J., & Vink, A. C. (2018). Music-based therapeutic interventions for people with dementia. *Cochrane Database of Systematic Reviews*, *5*(7), Cd003477–Cd003477. https://doi.org/10.1002/14651858.CD003477.pub4

Vink, A., & Hanser, S. (2018). Music-based therapeutic interventions for people with dementia: A mini-review. *Medicines*, *5*(4), 109. https://doi.org/10.3390/medicines5040109

Zuidema, S. U., Johansson, A., Selbaek, G., Murray, M., Burns, A., Ballard, C., & Koopmans, R. T. (2015). A consensus guideline for antipsychotic drug use for dementia in care homes. Bridging the

gap between scientific evidence and clinical practice. *International Psychogeriatrics*, *27*(11), 1849–1859. https://doi.org/10.1017/S1041610215000745

Zuidema, S. U., Smalbrugge, M., Bil, W. M. E., Geelen, R., Kok, R. M., Luijendijk, H. J., & Vreeken, H. L. (2018). *Multidisciplinaire Richtlijn probleemgedrag bij mensen met dementie demen-tie* [Multidisciplinary guideline for problem behaviour in dementia]. Verenso, NIP.

Appendix. List of deleted statements

People with dementia who can benefit from GMT

(1) GMT should be offered to all persons with dementia and behavioral and psychological symptoms.
(2) GMT is less appropriate for persons with dementia at the first stage of the disease, which is characterized by a decrease in memory functions, disorientation, and changes in personality.
(3) GMT is less appropriate for persons with dementia at the middle stage of the disease, which is characterized by decreased memory functions, an increase in major psychological disorders such as hallucinations and psychoses, and an increase in behavioral disorders such as verbal and physical aggression.
(4) GMT is less appropriate for persons with dementia at the latest stage of the disease, which is characterized by a decrease in overall functioning: inability to speak, family members are no longer recognized, the loss of psychomotor skills, person becoming bedridden.

Short-term goals within therapy

No statements deleted

Long-term goals for therapy after repeated sessions

(5) The short-term goals (such as social engagement or stress reduction) do not necessarily serve the long-term goals (improvements of behavior and mood).

Therapy Frame and Content

(6) Receptive music therapy is appropriate in GMT for persons with dementia. Receptive music therapy means in the context of my sessions that persons listen to music played on playback equipment.
(7) During GMT for persons with dementia the therapist can make use of a designed structured manual, including guidance in relation to improvisation, which may improve the replicability of a music therapy intervention.

Assessment and Preparatory Sessions

(8) An observation session should take place in order to finalize a decision regarding the inclusion and exclusion of the persons to the GMT sessions.

Elements of a GMT session to make GMT person-centered

(9) Each GMT session should have its own therapy goal, which can differ per session.
(10) GMT sessions should have a topic and the songs used should be selected according to the topic.
(11) In the main phase of the GMT session one should focus on improvisation in which the participants express their feelings.
(12) During GMT sessions the participants are allowed to leave whenever they want.
(13) During the GMT sessions the therapist talks about the participants' emotions.

(14) During the GMT sessions participants **should** be invited to reflect upon their individual biography, for example, when choosing songs to sing.
(15) During the GMT sessions therapists **should** choose songs or music to listen to according to the emotional states of individual group members or of the whole group.
(16) At the end of a GMT session the therapist should ask for a short reflection of the therapeutic experience.

Therapists' Qualities and Attitudes

No statements deleted